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| **Privacy Notice Statement** |
| Please note by completing this referral, Compass will expect the following (please tick to confirm):   1. This referral has been discussed and agreed by the parent/carer (if under 16 years) and service user 2. You consider the service user to have capacity to give informed consent 3. You have explained that any information held on this form will be stored by Compass on a secure database   Signed by referrer:…………………… Signed by parent/carer:………………..…… Signed by service user:…………..…………. |

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| **OFFICE USE ONLY** | | |
| Date referral received: | Duty Worker: | Allocation Date: |
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| Compass Barnsley Mental Health Support Teams (formerly known as Mindspace) works with young people and families, schools and colleges in Barnsley. We provide therapeutic interventions to young people and their families who attend one of the 10 secondary schools.  Please tick the box below which related to the type of support required:  One-to-one therapeutic interventions for young people  One-to-one family support. This support could involve; emotional support parent/carer and child, child  behaviour support, self-help strategies and signposting to other services.    In order to make a referral to Barnsley MHST… please note the following inclusion and exclusion criteria.  Barnsley MHST… **can** support children and young people with (please tick those that apply):  Low mood: sadness, low motivation  Mild to moderate anxiety: worries, irrational fears and concerns  Common challenging behaviours; angry outbursts, pushing boundaries, frustration and distress  Family and peer relationship difficulties  Difficulty adjusting to change and transition  Difficulty managing emotions  Barnsley MHST… **cannot** work with children and young people who:   * Are currently referred to any other emotional-wellbeing service (within the School or externally). * Have a clinical diagnosis of ‘clinical’ depression, severe anxiety, Obsessive-Compulsive Disorder (OCD) , schizophrenia, eating disorders, psychosis. * Have self-harmed long term and currently experiencing suicidal thoughts/behaviours * Have severe ADHD and ADD * Have a moderate – severe learning disability * Are requiring long-term therapy * Are in crisis or requiring out of hours support   **PLEASE NOTE**: If you are unsure whether a child or young person would benefit from support from Barnsley MHST please call the team on 01904 666371 (Monday – Thursday 9am to 5pm / Friday 9am to 4.30pm).  ***It may be deemed necessary to speak to the referrer to discuss the referral in more. please note that it may hold up the referral if a Practitioner is unable to speak with the referrer*** | |
| **CONTACT DETAILS OF REFERRER** | |
| **Name:** | **Relationship to child/young person:** |
| **Organisation (if applicable):** | |
| **Address:** | |
| **Referrer’s contact phone number:** | |
| **Referrer’s email address:** | |
| **Has the young person consented to this request for support?** Yes  No | |
| **Has the child’s parent/carer (if under 16) consented to this request for support?** Yes  No | |
| **Has the young person consented to being contacted via text message?** Yes  No | |
| **Has the parent/carer consented to being contacted via text message?** Yes  No | |

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| **CONTACT DETAILS OF THE CHILD OR YOUNG PERSON** | | | | |
| **Child/young person’s full name:** | | **Preferred name/pronoun:** | | |
| **Child/young person’s address:** | | | | |
| (*NB we may correspond by post unless referrer explicitly instruct us not to)* **Postcode:** | | | | |
| **Child/young person’s mobile phone number:**  (*NB we may leave a message on this phone number unless referrer explicitly instruct us not to)* | | | | |
| **Child/young person’s landline phone number:**  (*NB we may leave a message on this phone number unless referrer explicitly instruct us not to)* | | | | |
| **Child/young person’s date of birth:** | | | **Age:** | |
| **Child/young person’s gender:** | | | **Religion:** | |
| **Ethnicity:** | White  Mixed  Asian or Asian British  Black or Black British  Other Ethnic Groups  Not known | | **Main Language:**  (Is an interpreter required? If so specify language) | Documents required in main language |
| **Next of Kin:** | | | | |
| **Accommodation status:**  (i.e. living with parents, living with relatives, fostered, adopted, independent living) | | | | |
| **Are there any methods by which the child/young person does NOT want to be contacted?** | | | | |
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| **CONTACT DETAILS OF PARENT/ CARER** | | | | |
| **Parent/carer’s name:** | | | | |
| **Relationship:** | | | | |
| **Parent/carer’s address:**  (NB we may correspond by post unless referrer explicitly instruct us not to) | | | | |
| **Parent/carer’s contact phone number:**  (NB we may leave a message on this phone number unless referrer explicitly instruct us not to) | | | | |
| **Parent/carer’s email address:**  (NB we may correspond by email unless referrer explicitly instruct us not to) | | | | |
| **Other parent/carer details:**  (NB we may contact the other parent/carer unless referrer explicitly instructs us not to) | | | | |
| **Main language of parent/carer:** | | | | |
| **Is an interpreter required? If so please specify language:** | | | | |
| **SCHOOL/COLLEGE DETAILS (if applicable)** | | | | |
| **Name of the school the young person attends:** | | | | |
| **Year group:** | | | | |
| **Name of key contact / member of staff at school:** | | | | |
| **Telephone number of the school:** | | | | |
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| **GP DETAILS** | | | | |
| **G.P name:** | | | | |
| **Name and address of G.P surgery:** | | | | |
| **Phone number:** | | | | |
| **Email address:** | | | | |
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| **DOES THE YOUNG PERSONAL HAVE ANY ADDITIONAL NEEDS** | | | | |
| Subject to a CPP | | | Yes  No  Don’t know | |
| Elected Home Educated | | | Yes  No  Don’t know | |
| LAC/Care Leaver | | | Yes  No  Don’t know | |
| Young Carer | | | Yes  No  Don’t know | |
| Excluded / at risk of | | | Yes  No  Don’t know | |
| Substance Misuse | | | Yes  No  Don’t know | |
| NEET | | | Yes  No  Don’t know | |
| Special Educational Need or Disability (SEND) | | | Yes  No  Don’t know | |
| Physical health needs (including allergies) | | | Yes  No  Don’t know | |
| Mental health diagnosis (e.g. ASD, ADHD, PTSD, OCD, anxiety, depression) | | | Yes  No  Don’t know | |
| Education Health and Care Plan (EHCP) | | | Yes  No  Don’t know | |
| Previous mental health intervention (e.g. CAMHS, counsellor, Ed Psychologist) | | | Yes  No  Don’t know | |
| Please provide more details: | | | | |

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| **Please give a brief summary of the difficulties the child/young person is experiencing:** (including background information) |
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| **Are you aware of any current or previous risks associated with working with this CHILD/young person? If you have an existing risk assessment please attach:**  (please include any risks to self, others and safeguarding concerns) |
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| **Please list any other agencies involved in supporting the CHILD/young person:** |
| Does the parent/carer (if under 16) or young person consent to Compass contacting the agencies above to discuss the referral if required? Yes  No |
| **What would the CHILD/young person or PARENT/CARER like to achieve by accessing Barnsley MHST** |
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| **Any other relevant information:**  *(including: family, social, educational factors, school attendance and school attainment level)* |
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**Once completed please send the completed referral form to:**

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| **Email (MUST BE SECURE):** |
| **Secure\* email address:** [**info.barnsleyMHST@Compass-uk.org**](mailto:info.barnsleyMHST@Compass-uk.org)  \*NB In order for this to remain secure you must use an egress email address to send the referral |
| *If you are unable to send the referral securely please contact Compass on the number below.* |
| **Telephone number –** 01904 666371 |

If you have any questions you can call the duty line on 01472 494 250 Monday – Thursday 9am to 5pm / Friday 9am to 4.30pm

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